Stanford
HEALTH CARE ADVANTAGE

HOW TO SUBMIT YOUR MEDICARE PART C MEDICAL SERVICES APPEAL

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Your appeal is handled by different reviewers than those who made the original unfavorable decision.

Expedited Medicare Appeals can be requested by calling Stanford Health Care Advantage at 1-855-996-8422 (TTY: 711)

Standard Medicare Appeals must be received in writing and signed by the Member.

If the appeal is requested by a doctor or a family member, an Appointment of Representative Form (AOR) must be signed by the member and the representative. If you require this form, you can download a copy at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html, or contact Stanford Health Care Advantage at 1-855-996-8422 from 8 a.m. to 8 p.m., seven days a week from October 1 to February 14 (except Thanksgiving and Christmas) and Monday through Friday (except holidays) from February 15 to September 30 and TTY users can call 711.

Please send your written appeal to:

Stanford Health Care Advantage
Attn: Grievance & Appeals Department
P.O. 72530
Oakland, CA 94612
Fax: 510-588-5506

If you have any questions, please call our Member Services Department at **1-855-996-8422 from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 to February 14 and Monday through Friday (except holidays) from February 15 to September 30 and TTY users can call 711.**

One of our representatives will be happy to assist you.

PLEASE SUBMIT ANY SUPPORTING DOCUMENTS WITH YOUR APPEAL

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MEDICARE PART C - MEDICAL SERVICES
MEDICARE WRITTEN APPEAL FORM

You have a right to an appeal if you believe you are entitled to a service or benefit that has been denied. Please complete the following information to file an appeal:

PROCESSING TIME
Standard pre-service = 30 Days
Standard post-service and all Claims = 60 days
Expedited pre-service appeals = 72 Hours

An **expedited** appeal is only available when the standard process could seriously jeopardize life, health, or the ability to regain maximum function. Expedited requests not meeting one of these criteria will be transferred to the **standard** process.

ALL CLAIM APPEALS ARE PROCESSED AS STANDARD APPEALS

☐ **Request for Standard Appeal** **or** ☐ **Request for Expedited Appeal**

Member Name: _____ **Member ID:** _____

Address:

_____

(street, city, state, zip)

Member Phone #: _____**Alternate #:** _____

Provider Name: _____ **Provider Phone:** _____

Provider Mailing Address:

_____

Please describe what was denied:

_____

_____

_____

Please describe why you believe you are entitled to the denied service or benefit:

_____

_____

_____

Member Signature:

_____

Name of Person Submitting Appeal (if applicable): **Date:**

_____

Signature of Person Submitting Appeal (if applicable): **Date:**